Assay are as shown (PPV = Pos. Predictive Value; NPV = Neg. Predictive Value):

Concordant Results	Discordant Results	Sens.	Spec.	PPV	NPV
460 (95.2%)	23 (4.8%)	97.2%	91.3%	94.2%	95.7%

Using the McNemar test, we found that the cutoff for the cTnT Rapid Assay was not significantly different (p = 0.40) from the specified 0.2 ng/mL ES-300 value for a hypothesis of 95% confidence.

Use of the cTnT Rapid Assay in triage or risk stratification strategies is promising because it uses EDTA whole blood, requires only 20 min, and has a 0.2 ng/mL cutoff that correlates well with the established quantitative assay used in other studies.

1009-85 The Value of Bedside Troponin T Testing in the Emergency Room for Risk Stratification in Patients With Chest Pain After Discharge From Hospital

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The value of a newly developed bedside assay for troponin T (TnT) measurements to predict coronary heart disease was recently demonstrated. We investigated, whether early bedside troponin T measurements in the emergency room are also useful for risk stratification in pts with suspected ischemic heart disease after discharge from hospital. We screened n = 236 pts (male/female 141/95, age 63 ± 15) presenting to the emergency room for the reason of acute chest pain 7 ± 5 hrs after onset of symptoms. Cardiac TnT was determined semi-quantitatively ad admission and after a six hours interval. Pts. with at least one positive test result were considered TnT positive. All pts were followed for one month after discharge from the hospital to record cardiac events (AMI, death) or the need for further interventions (coronary angioplasty: PTCA, bypass surgery: ACVB).

Results: 1 month follow-up after discharge:

	TnT positive n = 47	TnT negative n = 187	p value
Death	9 (19%)	2 (1%)	<0.01
AMI	12 (26%)	2 (1%)	<0.01
ACVB	1 (2%)	2 (1%)	n.s.
PTCA	6 (13%)	9 (5%)	n.s.

All events occured after discharge from hospital. Cause of death in the TnT negative group in two pts. was stroke and cerebral neoplasm. Two pts. in the TnT negative group developed myocardial infarction after exclusion of AMI 1 month before.

Conclusion: The present results suggest that rapid TnT measurements in the emergency room may allow early risk stratification and prediction of cardiac events after discharge in pts with suspected coronary heart disease.

1009-86 Low Molecular Weight Heparin (Dalteparin) in the Management of Unstable Coronary Artery Disease (FRIC)

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Aspirin and heparin reduce the risk of ischaemic events including death and MI in unstable CAD, but reactivation may occur when heparin is discontinued. Low molecular weight heparins (LWMH) have pharmacological and pharmakokinetic properties that may improve antithrombotic therapy and allow long-term treatment. The FRIC study is a multi-centre trial in patients with unstable CAD receiving aspirin and conventional antianginal treatment who were openly randomized to LMWH (dalteparin) 120 IU/kg b.w. 12-hourly SC or IV-heparin followed by SC heparin (APTT 1.5–2.0 X control) for 5–8 days during hospitalization. In a long-term treatment comparison, patients received either dalteparin (7500 IU/day) or placebo SC for 40 days according to a double-blind random allocation at entry to the trial. The primary objective of the study was to determine the efficacy and safety of dalteparin in reducing death, MI and recurrence of angina between day 6 and 45. Secondary outcomes were death, MI, recurrent angina or revascularization during the hospital phase. 1500 patients were recruited and the data from the hospital phase are shown in the table.

The data show no difference in the incidence of ischaemic events and in safety between the two treatments in the hospital phase. Comparison of the primary outcomes between the two treatment groups at day 45 will be presented.

Secondary Outcomes (Days 5–8) %	Dalteparin (n = 751)	Heparin (n = 731)	p
Death/MI/Recurrent Angina	9.3	7.8	0.42
Revascularization	5.2	5.8	0.48
Death/MI/Recurrent Angina/Revascularization	13.0	12.5	0.99
Major bleedings	0.9	1.0	

1009-87 Braunwald Anginal Class as Risk Factor for the Occurrence of Early and Late Clinical Events Following Coronary Angioplasty (PTCA) for Unstable Angina Pectoris (UAP)

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Background: Clinical events such as death, myocardial infarction (MI), bail-out, bypass surgery (CABG) and re-PTCA hamper early and late outcome of PTCA. This ancillary study investigated the effect of the severity of UAP on early and late adverse clinical outcome (occurring within 4 or 210 days).

Methods: The studied population enroled prospectively the HELVETICA study, in which recombinant hirudin (Hir) i.v. or i.v. + s.c. was compared to heparin (Hep) treatment. Braunwald's classification (BC) for UAP was used. BC I: New onset or accelerated AP, no rest pain. BC II: AP at rest within the past month, BC III: AP at rest within the preceding 48 hours.

Results: The table presents the percentage of patients experiencing early or late clinical events per Braunwald class and per treatment group or total population.

	Early events				Late events			
Treatment	Hir iv + sc	Hir iv	Hep	Total	Hir iv + sc	Hir iv	Hep	Total
N =	378	381	382	1141	378	381	382	1141
BC I (N = 416)	3.6	8.9	4.6	5.8	24.5	30.8	22.9	27.4
BC II (N = 489)	4.2	8.1	10.4	7.6	34.9	39.4	39.3	37.8
BC III (N = 236)	12.3	5.3	21.6	13.6	39.7	41.3	35.2	38.6
P (N = 416)	0.02	NS	0.00	0.00	0.04	NS	NS	0.00

Conclusion: Increased severity of unstable angina results in an overall significantly increased risk for the occurrence of early and late clinical events.

1009-88 Impact of Patient Delay and Thrombolytic Treatment on Mortality Among 5978 Patients With Acute Myocardial Infarction

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Background: Time from onset of symptoms of acute myocardial infarction (AMI) until admission in hospital is extremely important, as the greatest risk of death is within the first hours. Time from onset of symptoms until administration of thromlytic therapy (TT) is determinant of its efficiency in reducing morbidity and mortality.

Aim: To assess the impact of patient delay on short- and long-term mortality following AMI.

Methods: 6676 consecutive cases of AMI were admitted in 27 centers in Denmark from May 1990 to June 1992. Baseline characteristics, patient delay and treatment was registered. Data on mortality were extracted from the Danish Central Personal Register on the 15th July 1994. Patients were stratified according to delay into three groups 1) delay < 2 hours (n = 2039), 2) delay 2–6 hours (n = 2049) and 3) delay > 6 hours (n = 1890).

Results: In 5978 (89.5%) cases information on patient delay was available. Mean delay 9.1 hours and median delay 3.25 hours. 2512 (42.0%) patients were receiving TT. Six day survival rate was 95% in group 1, 94% in group 2 and 3 (NS). The one, two and three year survival rates were 82%, 75% and 70% in group 1, 79%, 72% and 66% in group 2, and 73%, 67% and 60% in group 3(p < 0.01). By comparing patients who received TT, to those who did not, it was shown that the difference between the three groups in survival rates only was observed among patients who received TT. One, two and three year survival rates were 88%, 84% and 80% in group 1, 84%, 79% and 73% in group 2, and 81%, 77% and 73% in group 3 for those who received TT. For those who did not receive TT, one, two and three year survival rates were 74%, 65% and 58% in group 1, 72%, 64% and 57% in group 2, and 71%, 64% and 57% in group 3. There was significant difference in survival rates between the three groups among patients who received TT (p < 0.01), but not when patients for various reasons were denied TT.

Conclusion: Patient delay in patients admitted alive with an AMI had no